Resident Records and Credentials
Affidavit and Authorization for Release of Information

I, the undersigned, hereby certify under oath that I am the person named below, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named on this form and credentials furnished or to be furnished with respect to my request and that all documents, forms or copies thereof furnished or to be furnished with respect to my request are strictly true in every aspect.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind.

I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

____
Physician's Printed Name

______________________________________ ______________________
Physician's Signature Date of Signature

____
Resident Program Physician Attended

Please forward the information to:

____
Company and/or Individual's Name

____
Address Line 1

____
Address Line 2

____
City State Zip Code

Fax this completed form to (817) 868-5099 or mail to:
FCVS/ P.O. Box 619850/ Dallas, TX 75261